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Community-based Mealtime Management for Adolescents with Anorexia Nervosa: A Qualitative Study of Clinicians' Perspectives and Experiences

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Community-based Mealtime Management for Adolescents with Anorexia Nervosa: A Qualitative Study of Clinicians' Perspectives and Experiences

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ABSTRACT

Problem: Community-based mealtime management is an intensive, focused, and time-limited intervention for young people with an eating disorder which aims to support re-feeding at home and thus prevent hospital admission. Little is known about clinicians' experiences of delivering this intervention. We aimed to explore mental health clinicians' perspectives on community mealtime management with children and adolescents diagnosed with an eating disorder.

Methods: A qualitative design was employed. Semi-structured interviews were conducted with six mental health clinicians with experience of delivering or referral for the intervention. Interview recordings were transcribed and subjected to a thematic analysis.

Findings: Analysis resulted in identification of three themes: i) technical aspects of mealtime management; ii) emotional aspects of mealtime management; iii) a mixed zone of uncertainty around the use of dietary supplements. Overall, participants believed mealtime management to be a valuable intervention.

Conclusions: Findings highlight the perceived need for more formal training for clinicians undertaking mealtime management, and the positive impact this could potentially have on their practice. Clinicians' emotion regulation during intervention delivery was perceived to be important. There was a perceived need for greater adherence to protocols but an acceptance that flexibility was also required.

Keywords: anorexia nervosa, eating disorder, community mealtime management, adolescent, child

INTRODUCTION

Onset of anorexia nervosa most commonly occurs during adolescence, is most prominent in females (Bezance & Holliday 2014), and has significant physical and psychological implications (Couturier, Kimber,& Szatmari 2012). It has the highest mortality rate of any mental health condition; in adolescents, 1.8% die and 17% remain unwell for the long term as a result (Beukers, Berends, de Man-van Ginkel, van Elburg, & van Meijel, 2015). A recent population-based study estimated the lifetime prevalence of the condition to be 0.9 % for women and 0.3 % for men (Bravender, Elkus,& Lange 2017). Anorexia nervosa becomes treatment resistant over time and successful intervention during childhood onset can prevent chronicity (Bezance & Holliday 2014; Lock *et al.* 2015). However, limited research has addressed treatment effectiveness for young people with an eating disorder (Couturier *et al.* 2012), and there is no evidence from well conducted clinical trials to support any single intervention in terms of optimum weight restoration (Rocks Pelly & Wilkinson 2013).

Of the currently available therapeutic approaches, family-based therapy (FBT; Eisler, Dare, Hodes, Russell, Dodge, & Le Grange 2000; Russell, Szmukler, Dare, & Eisler 1987) has the best evidenced base, though direct comparison with other interventions is scant (Mairs & Nicholls 2016). FBT is commonly offered as the first-line treatment option and focuses on behavioural change. Proponents regard parents as the experts with regard to their children and aim to empower them to take charge until recovery begins (Mairs & Nicholls 2016). The approach comprises around twenty family sessions across a one-year period (Lock & Le Grange 2013). Results of randomised control trials of FBT for adolescents who have experienced a relatively short period of illness are encouraging. Between 50 and 75% participants return to a healthy weight and relapse rates are low (Lock *et al.* 2015; Madden *et al.* 2015; Mairs & Nicholls 2016). Further, outpatient treatment can be as effective as an

inpatient stay (Lock & Le Grange 2016). Nevertheless, slow early progress can suggest poorer outcomes (Lock *et al.* 2015).

An alternative approach focuses specifically on mealtime management i.e., providing support directly during mealtimes. Research into mealtime management in the hospital environment has focused on how the care staff manage patients' mealtimes; for example, whether rules should be adhered to (Hage, Rø, & Moen 2017); exploring the perspectives of patients with anorexia nervosa (Long, Wallis, & Meyer 2011; Offord, Turner, & Cooper 2006); and restoration of normal eating behaviour (Beukers *et al.* 2015). Adapting the mealtime management approach for community settings has been identified as potentially beneficial (Long *et al.* 2012). Since mealtimes can be the most challenging and demanding experience for parents, supporting them during this time is a crucial aspect of community mealtime management (Bezance & Holliday 2014). The intervention is primarily nurse-delivered and aims to restore the child's eating behaviours (Bakker, van Meijel, & van Elburg 2011; Beukers *et al.* 2015), promote calorie consumption and appropriate weight gain, empower parents to support their child at home (Kells, Davidson, & McCabe 2013), and ultimately prevent hospital admission (Bakker *et al.* 2011).

However, while individual care facilities and organisations have established clear protocols and procedures for mealtime management within various settings, the effectiveness of the intervention is poorly-evidenced particularly with regards to its use in the community (Long *et al.* 2011). In brief, it is not known what techniques are most likely to be optimal or whether clinicians experience particular difficulties or barriers during delivery. In addition, there is growing recognition that intensive community support rather than hospital admission rightly provides patients with the least restrictive treatment option (Bezance & Holliday 2014; Duffy & Skeldon 2014; Scottish Executive 2005). In the UK, National Institute for Health and Care Excellence (NICE 2004) guidelines recommend that specialist outpatient

interventions should be utilised in the first instance; this has also been found to be an important contributor to patients' treatment satisfaction (Long *et al.* 2012).

Aims and Objectives of the Current Study

In the context of the limited evidence base for community meal time management we have conducted a study to explore the perspectives of mental health clinicians' who deliver or indirectly use the intervention via referral. We aimed to use the insights gained to further refine the operationalisation of community mealtime management, and identify priorities for related training and education. Specific objectives were; i) to explore mental health clinicians' perspectives on delivering community mealtime management or referring their patients for the intervention; ii) to establish whether, and if so which aspects of, the intervention are perceived as effective or not; and iii) identify what might make the intervention more effective.

METHODS

Design

A qualitative design using semi-structured interviews was utilised given the study aim was to obtain personal perspectives (Bell 2014; Gerrish & Lacey 2010). This approach generates considerable textual data for analysis and researchers can ask participants to elaborate (Parahoo 2014), and can explore and clarify any inconsistencies in their accounts (Barriball & While 1994).

Setting and Participants

The study was conducted in Child and Adolescent Mental Health Services (CAMHS) in one Health Board in Scotland, UK. In the study setting the community mealtime management intervention (see below) occurs over a six-week period, tapering in intensity over two-week periods from support at three meals per day to one. Sampling was conducted

purposively to include only those with relevant experience of delivery or knowledge of mealtime management. Eligible participants must have delivered the intervention to families on at least one occasion, or made two or more referrals for mealtime management to the intensive community team (ICT) which delivers the intervention. The final sample comprised six participants from four different teams; one consultant psychiatrist, one clinical nurse specialist, one nurse therapist, two staff nurses and one support worker (A-F) (see Table 1).

The mealtime management intervention

In the study setting, the intervention is delivered by a specialist Intensive Community Team (ICT) During the intervention an ICT clinician visits the family home at each mealtime. The ICT is, a nurse-led service which works alongside the referring multi-disciplinary locality team. It comprises nurses with a small amount of input from a psychologist. In addition to the mealtime management intervention the ICT will undertake vital signs monitoring and venepuncture, but the young person will continue to meet with their locality team case co-ordinator on a weekly basis who will undertake further physical health monitoring e.g., weight monitoring, reading of blood results.

While there is no formal training protocol for clinicians involved in mealtime management within the community, the following is typical of how the intervention is delivered. The mealtime intervention is delivered within the family home meals are prepared by the family according to a food plan devised by a dietitian and comprise regular food or, in part or whole, high-energy liquid nutritional replacements. The young person will preferably sit at the family dining table alongside the ICT clinician, who provides support but does not herself eat, and is given twenty minutes to consume their main meal and ten for their dessert in line with published recommendations (Bravender, Elkus, & Lange 2017). Subsequently, 30-minutes direct observation occurs to limit purging behaviours and

inappropriate exercise. It is often the case at this stage that the young person will eat their meal alone; however, some families may wish to continue to eat their meal alongside their child. It is imperative that during mealtimes the young person does not partake in manipulation techniques such as smearing or spoiling of food, hiding food within their mouths, in their clothes or in tissues (Bakker et al 2011; (Ramjan 2004). The ICT clinician will also be vigilant to “active sitting” this is when the person contracts muscles unnecessarily and they will also try to prevent any constant movements of the young person’s legs/feet and crossing of their legs (Bakker *et al.* 2011; Beat 2017). If such behaviours are observed, the clinician will draw the young person’s attention to these and encourage them to stop.

If appropriate weight gain occurs over the course of the intervention then the child is discharged back to their locality community team. However, flexibility is retained and the duration of the intervention is dependent upon weight gain. Where progress is absent the team may agree that a brief hospital admission is required.

Materials

Interviews comprised four open-ended questions with supplementary probe and cue items. The questions were based on a review of the mealtime management literature, and on the researchers’ experience. Interviews were approximately forty-five minutes in duration and were conducted in March 2017 (JW).

Procedure

Ethical approval was granted by Abertay University Ethics Committee. NHS Research & Development approval was granted by NHS Greater Glasgow & Clyde Health Board. Initially, an email was circulated within the Health Board explaining the purpose of the study and requesting expression of interest from individuals who met inclusion criteria. Potential participants were contacted and a suitable time and private location arranged to

conduct the interview. Interviews were audio-recorded and subsequently transcribed for analysis.

Data Analysis

Data analysis followed the six steps described by Braun and Clarke (2006): i) repeated reading of the interview transcripts to aid familiarity with the data set; ii) generation and review of an initial set of codes; iii) categorisation of themes under appropriate headings to develop a picture of how different codes fit together; iv) reviewing themes to determine whether they make a coherent pattern and whether the data extracts support the themes; v) defining and naming themes; and vi) further refining the analysis by repeatedly writing and amending the final report. Analysis was supported by regular discussion during supervisory meetings.

RESULTS

Six mental health clinicians (A-F) participated (see Table 1). Two overarching themes were generated by the analysis: i) *technical aspects of mealtime management*, and ii) *emotional aspects of mealtime management*. A third linking theme iii) *mixed supplementary zone*, centred on the technical issue of use of dietary supplements but manifested as an emotional response related to clinician empowerment. The entire process of mealtime management could be likened to a balancing of the technical and emotional aspects of care.

Theme 1: Technical aspects of community mealtime management

Preparation for success

Preparation for success as a sub-theme encompassed the factors perceived as necessary for clinicians to successfully deliver community mealtime management. Participants recognised that they received no formal or mandatory training before they

commenced delivery of the intervention for the first time. Relatedly, participants expressed that individual inconsistencies in delivery were common. It was evident that, while the participants felt the best way to gain experience was to deliver the intervention itself, this had perceived limitations in terms of fidelity to a rigorously defined approach.

“Nursing in itself, on the job, is where you learn most stuff but I do think it would be helpful to have a bit theory [sic], or some sort of maybe more formal, or a bit more prescriptive training.... to describe the purpose really and a care plan for mealtime management and the what to do and what not to do.” (Participant E)

“I think it just needs to be, more training, everyone needs to be singing from the one hymn sheet...” (Participant A)

Suggestions for training content involved new clinicians observing their more experienced colleagues’ role play a mealtime scenario, and tips on how to manage potentially difficult situations. However, participants felt that single role play exercises were essentially limited and that the most beneficial way to gain experience and confidence was by undertaking mealtime management in vivo.

“They have a lot of experience in managing, you know, the behaviours that can be associated with eating disorders so I think that’s the beauty of it.” (Participant D).

Referrer participants recognised a lack of consistency in terms of referral to the team for community mealtime management. Nevertheless, they felt they should be able to refer when they judged it appropriate. The current pathway is for families to be offered FBT as a first line intervention, but this was not considered appropriate when, as a result, referral came at a point of crisis (e.g., due to ongoing weight loss). Participants generally believed that

improved outcomes were linked to early referral for mealtime management since this was perceived to reduce the likelihood of the young person becoming medically compromised or subject to emergency mental health admission.

“[should] refer to ICT slightly earlier on in their illness before they are at risk of becoming more physically unwell and quite often cognitively they are not in a place where they understand...” (Participant F)

Managing mealtime management

This second of two technical sub-themes reflected participants’ understanding of the process of delivery of community mealtime management and what could potentially be different. Mealtime management was seen primarily as a nursing intervention, based on a nursing process and incorporating mental health assessment aided by observation skills to formulate an understanding of the function of behaviour exhibited by the child and the family during delivery.

“I don’t think they are just going out and feeding the child and that’s that. They are also doing assessment at the same time and helping the parents...” (Participant D)

Participants perceived benefits from their presence during mealtimes, notably they felt able to gather information about what was occurring during the meal, and highlight this to the parents.

“[the team]... go in and find things out you hadn’t realised, say the child was making all the meals kind of thing... You can then discuss this with them at your appointment.” (Participant D)

However, much of the focus of mealtime management was on immediate practicalities:

“... ‘you need to lift your spoon’. There might be times when you have to direct them through the physical action of eating.” (Participant E)

Some examples of these behaviours may be driven by anorexia nervosa and could involve the child trying to spoil their meal by smearing or hiding their food or trying to exercise during or after a meal.

“... they are trying to burn energy in the smallest ways possible so for example tapping their feet or shaking their legs.” (Participant B).

Most participants stressed the importance of having set mealtimes and the need for 'flexible structure'. For example, if the young person was managing to eat their meal but that it was evident they would require slightly more than the thirty minutes allotted, then this would be accommodated. Conversely, if it was clear that they would not be completing the meal within this time then the early use of supplement may be considered.

“If somebody is eating their meal and looks like they are going to finish it ...but are just going to be 10 minutes over this would be allowed...different if someone has not started their meal 25 minutes in....” (Participant F).

“you have to draw a line somewhere and that is a reasonable timescale, I think to sit with someone for over an hour trying to eat chilli or something that is freezing can be unfair.... you are trying to role model normal eating.” (Participant E).

All participants believed that it was important to keep the number of clinicians involved in any individual family's mealtime management to a minimum:

“If it is different workers every day unknown to the family and young person, I don't know how helpful that would be for containing the situation.” (Participant C)

However, this had to be balanced against the demanding intensity of the intervention (21 visits per week initially).

Theme 2: Emotional aspects of mealtime management

Anxiety for all

This emotional sub-theme related to clinicians' own emotional experience, most notably anxiety, during the delivery of mealtime management and in relation to training. Involvement in community mealtime management was viewed as particularly anxiety-provoking.

“In the beginning, I was anxious and especially when I started doing it in the community as you don't have the back up from other staff as you are going in alone to a family's home.” (Participant A)

Participants involved in mealtime management expressed anxiety related to the need to balance their individual style of delivery with overall consistency, and of the impact this can have on their confidence:

“[training] Possibly for confidence because everyone does mealtime management differently so a consistency thing it might be helpful....” (Participant F)

“It might be helpful to have some kind of training programme or something that would mean everyone was going out to the families and doing the same thing. It could disempower the clinician when they are going in ‘cause they [the family] might say “such and such did it this way...” (Participant F)

Anxiety, manifesting as self-doubt, was experienced by participants when the child/adolescent displayed increased stress levels and/or exhibited increased levels of distress or self-harm behaviours.

“is it me that caused that young person to lose weight? Am I doing the right thing? So, you maybe look at your own way, you look into yourself.” (Participant F)

Participants spoke of anxiety both at transition points in the mealtime management process (i.e., reduced number of supported meals) and prior to discharge of the family back to specialist CAMHS.

“sometimes you can feel a bit lost yourself, anxious when it is coming to an end, in terms of the six weeks because you might want ICT [sic] to be involved for longer.”(Participant D)

The participants recognised that supervision is essential when working with this group of children/adolescents. The data suggested there is an expectation from the wider CAMHS teams that supervision should be led by the local specialist eating disorder team rather than through the ICT peer supervision.

“When you are working in the community and when you are on your own that’s when it is important to have a chance to reflect on the process....” (Participant E)

“I hope that ICT get supervision through someone with an eating disorder specialism and someone who understands that.” (Participant C)

Taking Control/ Giving Control

This, the second of two emotional sub-themes, captured the participants’ perceptions of the transfer of power brought about by the introduction of community mealtime management. Participants highlighted that referral to the ICT came at a time when the young person often has not gained weight during other treatment, has presented in crisis following emergency referral from primary care, or are unknown to CAMHS. In all of these circumstances the inference was that the young person was at elevated risk of medical compromise. For participants, this justified a prescriptive treatment approach:

“You have to consider how underweight that person is and if their weight is not shifting in the right direction and their bloods may be off, something else needs to happen.” (Participant E)

Participants emphasised the importance of the intervention in prevention of hospital admission whether to a psychiatric or medical hospital setting. Community mealtime management was viewed as the intervention of penultimate resort, yet seen as considerably more favourable than hospitalisation:

“I think it is a good thing and at that point if they are struggling with FBT, you know, I think you reach a point where you have to put that to the side and it is now about physical restoration at that point, you need to step in and just get the calories in to them...” (Participant D)

Interestingly, the clear acknowledgement of a professional taking back of control (“*step in and just get the calories in to them*”) could be juxtaposed against claims that the intervention was in fact in the best interests of patients and their families:

“Being in their own home, surrounded by their families is probably the best place for them. Mealtime management in the home is definitely more beneficial...and it is possibly less distressing for them than to be in hospital.” (Participant F)

Participants recognised the importance of offering support to the families during the mealtime management process. It was acknowledged that, when the ICT first become involved, families may be at crisis point and finding it difficult to manage their child’s meal. Therefore, participants sometimes viewed family members as actively ceding control:

“...some family members find it a little bit too difficult to start maybe, so they might be keeping more of a back step initially.”

However, some participants articulated the importance of empowering the family and it was frequently described that mealtime management represented an opportunity to empower the family and help them regain lost confidence.

“...you also want to empower the family to take a bit of control back as well.” (Participant F)

Taking control was viewed as a temporary state of affairs, and it appears to be recognised that, while the structure of mealtime management is necessary for the young person's physical health, it cannot continue indefinitely.

Theme 3: The mixed or ‘supplementary’ zone

The issue of dietary supplement use appeared to represent a meeting of technical and emotional aspects of mealtime management. We use the term 'supplementary', therefore, to

refer not only to dietary or nutritional products including "any consumed products that aim to supplement the diet and provide additional nutrients that may be missing from it, or aren't being consumed in sufficient quantities" (NHS Choices 2011: pp. 1-2), but also to an abstract professional and social space. This space was characterised by clinician uncertainty or dissonance which sits comfortably neither simply as a technical issue to be resolved nor simply and solely as an emotional issue requiring conscious regulation: hence a supplementary zone. At face value, dietary supplement use simply arose as the result of a playing out of the mealtime management process. From the participants' accounts, however, there were inconsistencies in the use and prescription of these supplements. Citing these inconsistencies, it was apparent that some participants felt it outside of their control whether dietary supplements could be used or not in the absence of a formal prescription. This appeared to make participants feel disempowered when they are leaving a family when a young person has not completed a meal.

"Have a plan in place so if this kid refuses to eat at home then we have an alternative to offer then, when we walk away or when I personally walk away and this child has not eaten or managed to eat then I am kind of left thinking, I have not actually done anything..." (Participant B)

DISCUSSION

We investigated the views and experiences of mental health clinicians about a community mealtime management intervention for young people with an eating disorder and their families. The intervention was delivered in the context of participants' work in or with an intensive community service. While studies have been undertaken about mealtime management in the hospital setting (Bravender *et al.* 2017; Hage *et al.* 2017; Long *et al.* 2011; Offord *et al.* 2006), this study demonstrates that those delivering the intervention in

the community may experience additional complexity due to the relative isolation and intensity of their work, and the lack of access to immediate support. Weight gain and prevention of hospital admission were reported as the main drivers of the intensive intervention and were key indicators of perceived effectiveness. Some authors have suggested that the rationale for mealtime management is to assist patients to learn new skills in relation to eating (Bakker *et al.* 2011; Long *et al.* 2011), to provide a normative experience through replication of a typical meal for a child without an eating disorder, or to emphasise the importance of calorie intake at this stage (Couturier & Mahmood 2009). However, in this study participants focused on the temporary wresting of power from the child in pursuit of short-term safety.

Previous literature suggests that mealtime management approaches can enable and empower parents to support their child at home at the time of utmost strain (Cottee-Lang, Pistrang & Bryant-Waugh 2004). Current findings suggest that participants have confidence in the intervention. Primarily, it is anticipated to prevent hospital admission suggesting it is trusted that children can be safely treated in the community in the first instance (Gowers *et al.* 2002; Ryan, Malson, & Kohn 2006; Bezance & Holliday 2014), using the least restrictive treatment option (Scottish Executive 2005; NICE 2004). Parents have previously reflected on “hitting rock bottom” prior to the commencement of intensive support and have expressed how challenging mealtimes can be (Bezance & Holliday 2014; Long *et al.* 2012). and it is reported parents find respite from supervising meals at home and observing modelling from clinicians regarding meal management (Bravender, Elkus & Lange 2017). The current study suggests that, due to the child’s distress, support for families was essential during the ICT’s involvement. Despite the treatment deliverers' focus on gaining control, a key role of the intervention, from their perspective, did appear to be about supporting the family and encouraging their involvement.

Participants felt that the timeframes offered for intervention were adequate and reflected on the rationale that meals could not run in to one another due to the resulting distress caused. However, there is limited available research concerning the rationale for the time-frames used and how best to direct a child through a mealtime. Some suggested strategies include distraction and relaxation techniques (Beukers *et al.* 2015; Hage *et al.* 2017).

Research has emphasised the need for a rules-based approach when delivering the mealtime management intervention in order to help break down entrenched eating disordered behaviours (Hage *et al.* 2015). However, evidence for any specific detailed protocols is lacking (Long *et al.* 2011, Mairs & Nicholls 2016). Participants in this study readily identified practice variations and defined them as problematic. Notably, the use of supplements was the main area of contention. Participants were aware of the disadvantages of supplement-use but spoke of the negative impact they themselves experienced when ending an intervention where the young person has not consumed any food. Whether more or fewer rule-based approaches are warranted, it seems clear that, concerning dietary supplement use, treatment-delivering clinicians believe that clearer rules would bring greater certainty. It may be advantageous for ongoing education to cover the rationale for the use of dietary supplements. However, further investigation is required on variation in their use. Future guideline development should be based also on perspectives from individuals who have experienced eating disorders and successful mealtime management approaches (Long *et al.* 2011) since interventions that are overly structured provide can be inflexible and may result in disengagement (Hage *et al.* 2015).

Implications for practice

Table 2 shows our distillation from the research data of the needs and requirements of clinicians and service providers across the unfolding process of community mealtime

management. We have derived implications for both in terms of the themes derived from their data (technical, emotional, supplementary) and, temporally, i.e., before during and following the community mealtime management intervention. The experienced clinicians delivering mealtime management in this study were comfortable with the range of activities and roles that are central to clinical practice in mental health, notably the need to maintain personal development and learning, commitment to evidence-based practice, and working in partnership (Department of Health 2004). Importantly, nurses must focus on the young person's emotional and psychological recovery as well as their physical recovery during their intervention (Bakker *et al.* 2011, Beukers *et al.* 2015). Service providers, in turn, need to develop the environment in which such capabilities can flourish, including appropriate educational opportunities and supervision.

The provision of adequate workforce staffing to ensure this intensive intervention is sustainable is key to its success. Our findings suggest that the number of clinicians involved may have an impact on the approach. While this clearly involves ensuring adequate staffing it also requires consideration that fewer clinicians involved in any single case might result in fewer discrepancies and promote the therapeutic relationship which, per se, can improve experience of treatment (Bakker *et al.* 2011; Hage *et al.* 2015; Zugai, Stein-Parbury, & Roche 2012).

In this study, the focus of mealtime management was firmly on weight restoration, and parental support, and not on active psychotherapeutic work. Some may consider this to be overly reductionist; however, weight restoration can significantly improve cognitive impairment (Rocks *et al.* 2014). Some adolescents themselves have recognised the need to be cognitively capable of engagement in and concentration on any psychological input to facilitate subsequent reflection on deeper issues (Offord *et al.* 2006).

The current study clearly indicates that the technical aspects of mealtime management delivery occurred, for participants, within an emotional context. The emotional responses of nurses involved in the intervention therefore needs addressing. This aspect of treatment delivery is even less well-developed from an evidence perspective than the technical aspects. The use of supervision is an important formal process of professional support and learning for mental health clinicians in all areas of practice and featured strongly in participants' comments. There is a need to develop evidence-based supervision programmes that can be widely operationalized. The 'mixed' or 'supplementary' zone identified by the analysis of data from this study is an important articulation of the complexity of frontline service delivery. It appears to be an area which requires especially strong interdisciplinary communication since it is largely the dietetic profession who hold responsibility for food-related prescriptions. The uncertainty expressed by participants in our study indicates a need for greater dialogue.

Limitations

There are a number of important limitations to the current study. Qualitative methods do not produce a representative overview of the phenomenon in question and are generally conducted to explore a specific phenomenon in a specific place and time and with a specific group of people (Leung 2015). The findings of this study are, therefore, provisional since the analysis is context specific and limited to one geographical Health Board. Interviews and transcripts can be open to multiple interpretations. However, verbatim quotation has been used throughout to illustrate the analysis and to improve viability (Ryan *et al.* 2006). Further, the study was conducted in the context of a Masters level dissertation which limited the time available to collect data; as a result we do not claim that we achieved theoretical saturation of the data i.e., no new issues arising from interviews. However, the absolute requirement to achieve saturation outside of grounded theory studies has been much debated (Bruce 2007;

Tracy 2010). Rather, it has been proposed that the quality of qualitative research be assessed more on the thickness or richness of the presented data – this being a reflection of the time spent collecting data in the field - than on saturation or generalizability (Tracy 2010). Interviews in the current study were typical of other semi-structured interviews used in qualitative research (DiCicco-Bloom & Crabtree 2006) and were purposeful in nature, i.e., conducted with an informed and knowledgeable population. Future research should aim to investigate mealtime management interventions in other settings and contexts since multiple models may be used in practice (Bezance & Holliday 2014). Such studies could be conducted quantitatively or qualitatively; for example, the use of video recording of mealtimes would allow greater in-depth analysis of what works. This study examined the perspectives of clinicians and it would be of great value to consider the views of patients with anorexia nervosa and their families to gain greater clarity on what is most effective in terms of support for them. Ultimately, the goal is to develop a training program for clinicians that helps them to provide a supportive and effective intervention which keeps people with anorexia nervosa out of hospital, helps them restore weight, and supports their families to take control. Future studies should therefore aim to further clarify the optimal training content through an iterative refinement process and test it under trial conditions with staff who have been trained against those with regular preparation.

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Table 1: Participants' characteristics

ID	Job title	Years CAMHS experience	Times involved in delivery of community mealtime management	Currently delivering community mealtime management	Times referral made to Intensive Community Team
A	Community mental health staff nurse	2-5	>15	Y	0
B	Clinical support worker	6-10	>50	Y	0
C	Clinical nurse specialist/nurse team lead	11-15	0	N	3
D	Consultant Psychiatrist	2-5	0	N	2
E	Nurse therapist	10-15	>30	N	1
F	Community mental health staff nurse	2-5	>30	Y	0

Table 2: Perceived personal and system support needs, and personal skills and attributes of clinicians during the process of mealtime management

Theme	Domain	Phase		
		Preparation	Delivery	Aftermath
Technical Aspects	Clinician	Engage in appropriate education/ training based on theoretical and practical aspects, care plan, consistency, observe others' delivery, role play	Observation, assessment, limits/direction versus flexibility, gain experience in delivery	Supervision. Reflection.
	System demand	Provide appropriate education and training, clear referral system	Staffing (sufficient but limiting unnecessary heterogeneity)	Provide specialist supervision opportunities.
Supplementary Zone	Clinician	Plan for supplement use	Assessment skills for supplement use	Perceived disempowerment when unavailable
	System demand	Policy/operational decisions and development re: prescribing of dietary supplements	Monitoring availability and appropriate use of supplements	Act on deficits detected and share good practice.
Emotional Aspects	Clinician	Specialist clinical supervision opportunities	Emotional self-management; Take control Give Control	Specialist clinical supervision opportunities
	System demand	Provide specialist clinical supervision opportunities. Plan for adequate staffing conducive to self-regulation.	Ensure adequate staffing conducive to self-regulation.-	Provide specialist clinical supervision opportunities